STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF CHILD SUPPORT

EMPLOYMENT TERMINATION NOTICE

Use this form to report termination of employees for whom you had a requirement to withhold child support or enroll the employee's children in a health insurance plan. Be sure to print your return address on the reverse side.

YOUR BUSINESS OR COMPANY NAME	
EMPLOYEE'S NAME	DCS CASE NUMBER
EMPLOYEE'S LAST-KNOWN PO BOX OR STREET ADDRESS	TELEPHONE NUMBER
EMPLOYEE'S LAST-KNOWN CITY STATE ZIP CODE	SUBJECT TO REHIRE? ☐ YES ☐ NO
NEW EMPLOYER'S NAME AND ADDRESS (IF KNOWN)	DATE TERMINATED BY YOU
	NEW TELEPHONE NUMBER

EMPLOYMENT TERMINATION NOTICE
DSHS 18-560 (REV. 04/2004)

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 256 OLYMPIA WA

POSTAGE WILL BE PAID BY ADDRESSEE

DEPARTMENT OF SOCIAL & HEALTH SVCS
DIVISION OF CHILD SUPPORT
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